Ontario Auto Insurance Three-Year Review: Access to Justice and A Balanced System

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Introduction

The Ontario Trial Lawyers Association (OTLA) was formed in 1991 by lawyers acting for injured persons. Our purpose is to promote access to justice for all Ontarians, preserve and improve the civil justice system, and advocate for the rights of those who have suffered injury and losses as the result of wrongdoing by others, while at the same time advocating aggressively for safety initiatives.

Our mandate is to fearlessly champion, through the pursuit of the highest standards of advocacy, the cause of those who have suffered injury or injustice. Our commitment to the advancement of the civil justice system is unwavering.

Our organization has over 1,500 members who are dedicated to the representation of wrongly injured plaintiffs across the province and country. OTLA's membership is comprised of lawyers, law clerks, articling students and law students. OTLA frequently comments on legislative matters, and has appeared on numerous occasions as an intervener before the Court of Appeal for Ontario and the Supreme Court of Canada.

OTLA welcomes the opportunity to make submissions as part of the Three-Year Review of Auto Insurance by the Financial Services Commission of Ontario (FSCO). Members of OTLA are well-positioned to appreciate the impact of the automobile insurance legislation and regulations on Ontarians, all of whom are compelled to access the automobile insurance system for compensation and/or treatment when injured in motor vehicle accidents. Since the implementation of no-fault insurance in 1990, OTLA members have worked on the front line assisting injured individuals with both their first-party and third-party auto-related disputes at FSCO and through the courts. Through this first-hand experience, cooperation with stakeholders and consumer groups, interaction with the insurance industry, and in-depth research, OTLA can offer valuable insights for this mandatory review. OTLA's input enhances consumer protection, improves the insurance product, and promotes the fundamental values of fairness and equity required of a product intended to protect all Ontarians. For these reasons, OTLA is a significant stakeholder in this mandatory three-year review and is well-poised to offer its commentary and submit recommendations.

Summary of Recommendations

OTLA recommends the following:

1. Eliminate the threshold in tort and thereby find substantial administrative cost savings; Page 10
2. Repeal the defining regulation in Section 267.5 of the *Insurance Act*; Page 10
3. Amend Section 276.5(8) and (8.1) of the *Insurance Act* to revise the language surrounding the application of the deductible so that damage awards equal to or greater than *$100,000, and $50,000 under the Family Law Act,* are exempt from the deductible rather than the current exemption applying only to awards that exceed $100,000 and $50,000 under the *Family Law Act*; Page 12
4. Return the deductible from $30,000 to its pre-2003 level of $15,000. The reduced deductible would apply to non-pecuniary claims assessed at less than $100,000; Page 12
5. Reduce the deductible for *Family Law Act* awards of less than $50,000 from $15,000 to $7,500; Page 12
6. Simplify, shorten and make more efficient the procedure for claiming, disputing and receiving Statutory Accident Benefits Schedule (SABS) benefits; Page 12
7. Reduce transaction costs in accident benefits; Page 13
8. Eliminate assessments for issues subject to a paper review Arbitration; Page 15
9. Limit insurer assessments to no more than once every 6 months; Page 15
10. Limit assessments to no more than 10 per cent of the available benefit amount on assessments; Page 15
11. Raise income replacement benefits from $400 to $600 per week, while maintaining the option to purchase higher income benefit levels; Page 16
12. Repeal recent changes to attendant care benefits; Page 19
13. Refine and narrow the scope of injuries falling within the MIG, so that injured persons can obtain the treatment that they require; Page 20

Overview of Conceptual Goals

These submissions pertaining to the review of Part VI of the *Insurance Act* are intended to achieve fairness and efficiency in automobile insurance while preserving the fundamental right of access to justice by Ontarians. OTLA seeks to ensure the restoration of tort rights, while maintaining appropriately priced premiums and a healthy and viable insurance industry. This goal can be accomplished in a number of ways, including changes to the Statutory Accident

Benefits System (SABS) that simplify practices, reduce complexity, and minimize transaction costs.

OTLA has consistently advocated for a balancing of the "3 Ps" of auto insurance – Protection, Premiums and Profits. Protection (in the form of the standard auto policy) has clearly been on the decline. The rights of innocent accident victims to pursue tort claims to recover their reasonable losses and to be meaningfully compensated for their pain and suffering have been consistently eroded for decades, with no appreciable restoration of those rights since 1996. The availability of Statutory Accident Benefits for the vast majority of accident victims was again slashed in September 2010 and continues to come under attack with recent restrictions to the SABS.

Throughout the same time period, however, premiums rose by more 20 per cent and have remained at these higher levels. Only recently have rates begun to fall to meet the government's 15 per cent reduction targets. Any reduction in premiums may be welcomed by Ontarians, but premium reductions without adequate protection provide little comfort to those same Ontarians when they are seriously injured in a car crash.

Of the three Ps, profits remain the great unknown and the subject of speculation. OTLA's independent analysis of the publically available data from the General Insurance Statistical Agency and the Office of the Superintendent of Financial Institutions indicates that Ontario auto insurance companies realized profits in excess of 15 per cent, and potentially as high as 25 per cent, since the September 2010 changes. For the years 2011 and 2012, Ontario auto profits were $1.4 billion and $1.6 billion, respectively.

Figures for 2013 are not yet available but trends would point towards continued enhanced profitability for the past year. It is doubtful that premium reductions will have a significant downward impact on profitability given the recent changes to the SABS, on top of previous Draconian accident benefits reductions which only serve to provide significant claims reductions. The profits enjoyed by the insurance industry that prompted the government to mandate the 15 per cent rate reduction, resulted from the watering-down of the insurance product.

Nearly four years after the 2010 changes, stakeholders still have no reliable information about the true scope of the cost savings to the insurance industry, and the profits that those cuts have generated. That is why OTLA applauded the following announcement in the 2013 Budget:

> *"The government will also create a transparency and accountability mechanism in the form of an independent annual report by outside experts on the impact of auto insurance reforms introduced to date on both costs and premiums. The report will review industry costs and changes to premiums paid by Ontario drivers, and make recommendations as to further actions that may be required to meet the government's reduction targets."*

This initiative was unprecedented for Ontario and likely for Canada. OTLA welcomes the notion of a transparency report and applauds the Minister and the government for proposing to bring it forward to help ensure accountability and transparency in auto insurance data. In committee appearances and in correspondence to the Minister, OTLA has indicated that this initiative will help bring clarity to a public policy area that for too long has been shrouded in secrecy and has been obfuscated largely because of the influence and control of the insurance industry. The province, OTLA contended, had a unique opportunity to ensure that policy review is predicated on sound analysis and respected data.

Unfortunately, nearly a year after the initiative was first announced, it has come to light that the Ministry of Finance has chosen KPMG, the firm which last year prepared the analysis for the Insurance Bureau of Canada on insurance industry profitability, to produce the province's first insurance transparency report. OTLA remains skeptical that the Ministry will achieve the goal of true independence, transparency and accountability given the choice of a provider with clearly established ties to the insurance industry.

We emphasize that increased access to justice for innocent accident victims must be a precondition to reform of first-party benefits. The quality of the product depends entirely on the proper balance between tort rights and first-party benefits. Proponents of the erosion of tort rights in Ontario have argued that this was justified by the need to fund the first-party system; however, the inequities and inefficiencies in the first-party benefits system lend credence to our view, shared by other stakeholders, that there must be a systemic realignment that restores rights and strikes a proper and sustainable balance. Put simply, the first-party system is too complicated and wastes substantial resources on costs that have nothing to do with helping accident victims recover from their injuries.

In September 2010, the Minor Injury Guideline ("MIG") was introduced. The MIG mandates that claims that categorically fall within a certain injury group (primarily muscular pain claims without neurological involvement) are limited to $3,500 of medical/rehabilitation coverage.

For injuries that fall outside the MIG, the accident benefit coverage made available for medical and rehabilitation expenses in non-catastrophic claims was dramatically reduced from $100,000 to $50,000.

Proportionality is an important concept that OTLA would like to see introduced into the SABS. The cost of the process for determining entitlement to a benefit can approach or, at times, exceed the amount of the benefit sought. Applications, reviews, assessments and the dispute resolution process itself, must be moderated to restore proportionality yet maintain fairness. Improved administrative efficiency and dramatically reduced reliance on process is critical to eliminating waste in the system.

In 2007, the Ontario Attorney General commissioned the Honourable Coulter Osborne to undertake a review of our civil justice system. This review culminated in the Civil Justice Reform Project report of November 2007 (the "Osborne Report"). In his report Justice Osborne insightfully noted: "Proportionality… simply reflects that the time and expense devoted to a proceeding ought to be proportionate to what is at stake."

Transaction costs, including assessment and administrative costs, associated with claims under the first-party benefit system are often too high in relation to the benefit sought. It is wasteful and inefficient when the time and money expended in determining entitlement to a particular benefit exceeds the actual value of the benefit claimed. The implementation of the Minor Injury Guideline in September 2010, with its cap of $3,500 in treatment costs, was intended to bring dramatic reductions in expenses associated with the first party benefit system. Insurers should have been able to reduce costs both in assessments and cost of counsel in MIG claims.

In Ontario, innocent accident victims have seen their tort rights steadily eroded in response to perceived threats to insurer profitability. On October 1, 2003, we saw a significant reduction in the tort rights of innocent accident victims when the deductible for non-pecuniary damages of $100,000 or less was increased from $15,000 to $30,000 per accident, and the deductible for *Family Law Act* non-pecuniary damage claims assessed at $50,000 or less was increased from $7,500 to $15,000 per claim. The increases in these deductibles have meant, simply, more profit for insurers and less compensation for innocent accident victims and their families.

In September 2010, the accident benefits system was again dramatically changed, resulting in even greater savings, and thus profits, for the insurance industry. The introduction of optional

benefits (which are seldom purchased by Ontarians), the MIG, and the new ceiling of $50,000 for medical and rehabilitation benefits for non-catastrophically injured claimants, have resulted in drastically lower net payments to injured people, and even more profit for the insurance industry. Having presumably recognized the savings, and resulting profits, that insurers have enjoyed, the Ontario government has mandated a 15 per cent decrease in automobile insurance premiums. Of course, lowering premiums while continuing to gut the tort and first-party benefit system will do nothing to assist hardworking Ontarians who are innocent accident victims and are facing dramatically increased financial burdens as a result of their injuries. Some of these financial burdens include being unable to work due to injury (our accident benefits system limits income replacement benefits to only $400 per week, unless an optional benefit has been purchased for increased coverage), and health care costs that are not covered by OHIP such as physiotherapy, massage therapy and psychological counseling.

One of the largest expenditures by the insurance industry is the aggregate cost of "independent assessments" by physicians and other medical assessors selected by insurers to assess the extent of an insured's disability, or the need for medical, rehabilitation or other benefits under the SABS.

Insurers spent $171 million on "insurer initiated assessments" for victims who were injured in accidents between January 1, 2011 and June 30, 2013. During that same time period, insurers spent $359 million on treatment for that same group. For every dollar that insurers spent treating someone to help them get better, they spent almost 50 cents assessing them. Those assessments, which often lead to denials of treatment, have a huge negative impact on a victim's emotional well-being and help to create the adversarial first-party benefits system that often forces victims to litigate with their insurers for years in order to obtain necessary treatment. Thus, for every dollar spent helping a victim to get better, 50 cents is spent making them worse!

Not every victim is assessed by his or her insurance company. For the oldest accident dates covered by the Health Claims for Auto Insurance (HCAI) data (accidents from January 1, 2011 – June 30, 2011), just under 50 per cent of all victims were assessed. For that 50 per cent who have been forced to go through insurer assessments, insurers spent substantially more assessing them than treating them. If all of the claims covered by this data are considered (January 1, 2011 – June 30, 2013), the average treatment cost over that 2.5 year time span is $2,938. The average assessment cost is $3,521. Insurers therefore spent 20 per cent more money assessing people than treating them!

Recall that this data represents accidents that have occurred since the introduction of the MIG and the substantial cuts to benefits in September of 2010. The vast majority of accident victims are placed in the MIG by insurers. How can insurers possibly justify spending huge sums of the premium dollars on assessments?

The Tort Regime

The Threshold

Restoring fairness to automobile insurance and improving access to justice are the main priorities for OTLA. Since November 1, 1996, there has been a verbal threshold in place preventing an injured person from suing the at-fault party unless the injured person can prove that he or she has suffered "a serious impairment of an important physical, mental or psychological function".

The Osborne Report expresses concern about the utility and fairness of the threshold. Even though automobile insurance was not specifically part of the Terms of Reference, the Honourable Coulter Osborne saw the threshold and deductible as matters of such importance in the context of access to justice that he felt compelled to address these issues in his Civil Justice Report.

Significantly, he observed the similar and overlapping purposes of the deductible and the threshold. Both are designed to take less serious claims out of the system. Having both is redundant. The Osborne Report questioned the merit in having the threshold exclude claims that exceeded the deductible. He further noted the substantial transaction costs (legal fees and costs for both injured parties and insurers) and the substantial cost of judicial resources utilized in addressing the issue of the threshold and judicially determining who is entitled to sue.

In order to see evidence of the tremendous waste incurred as a result of the threshold, one only needs to review any of the unsuccessful threshold cases. Each case involved a full trial, with both parties calling tremendous evidence, over a long period of time, and at great cost. The total cost incurred by the parties in presenting this evidence was likely greater than the actual damages being sought. As observed by Justice Osborne, these considerable transaction costs are entirely attributable to the threshold. It is in the public's interest to remove this inefficient, unnecessary and costly provision.

Importantly, Justice Osborne also noted that a threshold has "access to justice implications". OTLA agrees with these observations and seeks to restore access to justice for innocent accident victims. The Osborne Report urged the Superintendent of Financial Services to give due consideration to the concerns about the threshold and deductible. OTLA shares the concern that the public interest is not served by a threshold that excludes claims that exceed the deductible.

The Defining Regulation: What Does the Word "Serious" Mean?

This *Insurance Act* regulation was amended in 2003 to further define and restrict the term "serious" in the threshold. One of the tests for determining whether the injuries are "serious" applies to those who work. A different, more onerous (and therefore discriminatory) test applies to those who do not work. For employed people to be compensated for their pain and suffering, they must prove that their ability to do tasks at work has been compromised. Meanwhile, those outside of the workforce, such as homemakers, children, the elderly and the disabled, must prove that they cannot carry out most of their usual activities, before they are permitted to sue for non-pecuniary damages for their pain, suffering and loss of enjoyment of life.

The defining regulation appears at Ontario Regulation 461/96 as amended by 381/03 September 16, 2003

4.2 (1) A person suffers from permanent serious impairment of an important physical, mental or psychological function <u>if all of the following criteria are met</u>: (emphasis added)

The impairment must,

i. substantially interfere with the person's ability to continue his or her regular or usual employment, despite reasonable efforts to accommodate the person's impairment and the person's reasonable efforts to use the accommodation to allow the person to continue employment,

ii. substantially interfere with the person's ability to continue training for a career in a field in which the person was being trained before the incident, despite reasonable efforts to accommodate the person's impairment and the person's reasonable efforts to use the accommodation to allow the person to continue his or her career training, or

iii. substantially interfere with most of the usual activities of daily living, considering the person's age.

For the function that is impaired to be an important function of the impaired person, the function must,

i. be necessary to perform the activities that are essential tasks of the person's regular or usual employment, taking into account reasonable efforts to accommodate the person's impairment and the person's reasonable efforts to use the accommodation to allow the person to continue employment,

ii. be necessary to perform the activities that are essential tasks of the person's training for a career in a field in which the person was being trained before the incident, taking into account reasonable efforts to accommodate the person's impairment and the person's reasonable efforts to use the accommodation to allow the person to continue his or her career training,

iii. be necessary for the person to provide for his or her own care or well-being, or

iv. be important to the usual activities of daily living, considering the person's age.

For the impairment to be permanent, the impairment must,

i. have been continuous since the incident and must, based on medical evidence and subject to the person reasonably participating in the recommended treatment of the impairment, be expected not to substantially improve,

ii. continue to meet the criteria in paragraph 1, and

iii. be of a nature that is expected to continue without substantial improvement when sustained by persons in similar circumstances. O. Reg. 381/03, s. 1.

(2) This section applies with respect to any incident that occurs on or after October 1, 2003. O. Reg. 381/03, s. 1.

Since 1993, injured persons, their counsel, and insurers have obtained guidance on the interpretation of the threshold from the decision of the Ontario Court of Appeal in *Meyer v. Bright*. Neither litigants nor the courts have had much difficulty applying the clear direction from the Court of Appeal with respect to the application of the threshold. The introduction of the defining regulation in 2003 must, therefore, have been motivated by other interests; presumably those of the insurance industry.

Although the defining regulation has been in force since October 2003, there was no guidance from our courts as to its application prior to the April 30, 2008 decision of Madam Justice

Morrissette in *Nissan v. McNamee*. She found that the defining regulation created a more onerous test for the right to sue than had existed under the original threshold language considered by the Court of Appeal in *Meyer v. Bright*. Given the profits that have been realized by the insurance industry since the 2003 and 2010 amendments, there is no financial need, assuming there ever was one, or even the appearance of financial need, on the part of the insurance industry to prevent seriously injured persons from seeking fair compensation for their injuries.

OTLA has noted the Alberta decision in *Morrow v. Zhang,* 2009, in which a discriminatory auto insurance law was struck down. One of the constitutional lawyers involved in the Alberta challenge has provided an opinion to OTLA that the Ontario threshold-defining regulation and deductible are similarly discriminatory and as such are equally vulnerable to being struck down. By eliminating the threshold, the government will ensure that Ontario has constitutionally sound laws relating to auto insurance.

The 2003 amendments, in having dramatically restricted tort rights, have thereby created generous cost savings and thus profits for the insurance industry. Following the 2003 restrictions, the property and casualty insurance industry in Canada went on to mark record profitability, nearly doubling the 2003 profits of $2.2 billion to more than $4 billion in 2004. The Minor Injury Guideline has removed from the accident benefits system much of the expense and transaction costs for smaller claims, thereby creating even greater profit for the insurance industry. Modest estimates of the Ontario auto insurance industry's profitability suggest that the return on equity is in the range of 15-20 per cent and that total profitability has exceeded $3 billion in 2011 and 2012 alone.

Ontario drivers must surely be wondering how much more money the insurance industry needs to make before our government will take action to protect innocent accident victims. OTLA maintains that the extent of the profits and savings realized by the insurance industry since 2003 will readily allow for the elimination of the threshold without a resulting increase in premiums. Balance and fairness demands that the threshold be repealed.

At a minimum, OTLA seeks to have the defining regulation, which offends fundamental principles of justice and equality as recognized in our Charter of Rights, repealed in its entirety. This can be achieved through an amendment to the *Insurance Act*. It is observed that the regulatory changes made in 2003 that brought in these restricted tort rights, including the enhanced and discriminatory definition of “serious”, were made by order-in-council by the

executive council (cabinet) without legislative amendment. The removal of the defining regulation involving the word "serious" could similarly be achieved by order-in-council in cabinet without the necessity of legislative amendment.

The Deductible

The 2003 amendments to the *Insurance Act* also included an increase in the deductible imposed on all non-pecuniary claims of $100,000 or less from $15,000 to $30,000, and on *Family Law Act* awards for claims of family members of injured persons for their loss of care, guidance and companionship from $7,500 to $15,000.

This government regulation has had a staggering impact on ordinary Ontarians directly affected by an automobile accident. The deductible was meant to remove minor injuries from the system. By doubling the deductible, this regulation has effectively prevented seriously injured innocent accident victims – even those whose claims exceed the deductible – from receiving adequate compensation for the damages they have suffered, as the amount of the deductible dramatically reduces the actual amount of compensation an injured person can receive. For example, consider a construction worker hit by a drunk driver who suffers a broken limb. They will have a lifetime of pain and potential work limitations, and as a result their claim for pain and suffering claim might be worth $50,000 (but only $20,000 after the large deductible). The reality for this victim is that the cost of litigating this substantial and legitimate claim would likely not make it economically viable to pursue.

It has been argued that deductibles exist as a way to keep insurance premiums at an acceptable level. However, the changes brought forward by the 2010 *Insurance Act* amendments which drastically reduced costs for the insurance industry – including the creation of the Minor Injury Guideline and the dramatic lowering of the ceiling on medical and rehabilitation expenses from $100,000 to $50,000 for non-catastrophic claims – have resulted in more than ample savings to allow for a return of the deductible to pre-2003 levels.

Furthermore, OTLA submits that the monetary criteria for the application of the deductible to general damage awards should be changed in section 267.5 of the *Insurance Act* so that damage awards of $100,000 or greater are exempt from the deductible, rather than the exemption applying only to awards *over* $100,000.

This change would ensure that a very seriously injured innocent accident victim, whose claim for pain and suffering is assessed at $100,000, would not be subject to the $30,000 deductible that was intended to eliminate small claims.

OTLA is hardly alone in its position regarding the deductible. The Osborne Report also recommended varying the deductible. Justice Osborne likened the deductible to a "tax on pain". The stated purpose of the deductible, to keep the least serious claims out of the court system in order to bolster industry savings and reduce the strain on judicial resources, will still be achieved by returning the deductible to pre-2003 levels.

OTLA recommends the following:

- amend section 267.5 of the *Insurance Act* to revise the language pertaining to the application of the deductible to reflect that damage awards of *$100,000, and $50,000 under the Family Law Act, or greater* are exempt from the deductible (rather than the current exemption applying to awards *exceeding* $100,000 or $50,000 under the *Family Law Act*);

- reduce the deductible for non-pecuniary general damages on awards less than $100,000, from $30,000 to $15,000 (the pre-2003 change level);

- reduce the deductible for *Family Law Act* awards less than $50,000, from $15,000 to $7,500 (the pre-2003 change level);

Statutory Accident Benefits Schedule (SABS)

The interests of consumers require substantial reform of first-party benefits. This section considers some of the areas where adjustment is needed in order to achieve a proper balance for Ontario consumers in light of the erosion of tort rights and the dramatic reductions in the availability of first-party benefits.

It is entirely unacceptable to merely "tweak" the system, as any incremental approach to reforming first-party benefits is not in the public interest. In the last decade, attempts at tweaking the first-party benefit system have merely caused additional complexity, resulting in a more bloated and inefficient system. Further tinkering in this manner will simply perpetuate, and possibly add to, the problems we already face. OTLA suggests the return to a shorter, simpler accident benefit system reminiscent of the procedural mechanics from the Ontario Motorist Protection Plan.

The foremost priority concerns the complexity of the first-party benefit system. The sheer breadth, depth and complexity of the first-party benefit system contribute directly to wasteful costs. Consumers needing to access the accident benefit system are driven to obtain advice and services merely to begin to understand their rights. Insurers incur huge staffing expenses in order to deal administratively with the complexities of the first-party system. The number of required forms has increased, along with the cost of completing and processing the forms. Complexity also negatively impacts the timely assessment and delivery of benefits to injured people. Delaying benefits to those in need undermines the first-party benefit system and public confidence.

The second priority is transaction costs. The system is simply too expensive to administer. This cannot be overstated. There are far too many insurer assessments resulting in assessment-related costs being entirely out of control. Too much is being spent on transaction costs and assessments for relatively minor claims. These transaction costs represent premium dollars that do not find their way to injured people. The waste in respect of transaction costs is staggering. Ontario's first-party benefit system is not being delivered efficiently.

The third priority is proportionality. As in our civil justice system, the resources devoted to a matter in terms of time and money must bear some relationship to the value and importance of what is at stake. While this priority is tied to transaction costs, it is important to recognize that some transactions ought to be eliminated or substantially reduced simply because they do not make economic sense. This principle applies not only to the internal claims process of insurance companies, but also to the costs associated with the dispute resolution process.

Cost of Examinations and Assessments

Auto insurance premiums collected by insurers are intended to be used, in large part, to indemnify accident victims through the tort and accident benefits systems. While it is acknowledged that administering this compensation and treatment system has a cost, the administrative costs in doing so, in particular within the accident benefits system, have long since ballooned beyond reasonable levels. OTLA identified this concern in 2008 as part of the five-year review submissions, stating: "Transaction costs, including assessment costs and administrative costs in particular, associated with claims under the first-party benefit system, are frequently too high in relation to the benefit sought. It is wasteful and inefficient to spend more determining entitlement to a particular benefit than the actual value of the benefit

claimed. With enhanced tort rights and corresponding reductions in expenses associated with the first-party benefit system, dramatic reductions in transaction costs can be delivered."

The accident benefits system is too expensive to administer, particularly due to the number of unnecessary, adversarial medical assessments ordered by insurers. Data recently released by Health Claims for Auto Insurance (HCAI) speaks volumes in this respect. The oldest data available, representing accidents in the first half of 2011, provides a full 3 years of financial information about how insurers have spent those premium dollars. Insurers ordered medical assessments for 50 per cent of all accident victims. That is a staggering number. What is even more remarkable is the amount of money spent on such assessments: insurers paid an average of approximately $3,800 for treatment for these victims, while they paid an average of $4,400 for insurer-initiated examinations. This means that for the huge number of victims who were subjected to such assessments, the insurers spent significantly more money to assess those victims than to fund their needed treatment and rehabilitation. The total cost just for assessing that small group of accident victims was a staggering $60,000,000. Insurers' reliance upon these assessments has reached the point of addiction; one that our system cannot, and should not, tolerate, much less feed. OTLA stated the following in the 2008 submission – "The funds spent on transaction costs represent premium dollars that do not find their way to injured people. The waste in respect of transaction costs is staggering. Ontario's first-party benefit system is not delivered efficiently." Six years later, this statement is more compelling than ever.

It is clear from the objective HCAI data that insurers remain firmly addicted to their insurer assessments. In an era where benefits have been slashed in the name of saving money and reducing premiums, it is unacceptable to permit insurers to spend such a markedly disproportionate amount of every premium dollar on these assessments. The public has been asked to accept drastic reductions in benefits in return for lower auto premiums. What would that same public think about an insurance industry that sends half of all accident victims to assessments, and spends much more money assessing them than treating them? This current state of affairs is totally unacceptable and is not sustainable. Despite the huge cuts in September of 2010 that ought to have made assessments in most cases totally unnecessary, insurers have simply refused to reduce their reliance upon these assessments by choice. Therefore, changes must be made to ensure that this wasteful use of premium dollars does not continue. Once the changes to the dispute resolution system set out in Bill 171 are implemented, insurers should not even need assessments to deal with most issues.

Several possibilities that would curtail wasteful assessments include the following:

- No insurer assessments ought to be permitted for issues that are subject to a paper review Arbitration, such as whether or not someone is in the MIG, or treatment plans under a specified amount. A paper review is sufficient under those circumstances.

- No insurer assessments ought to be permitted more than once every 6 months. The assessors should be prepared to comment upon the foreseeable future so that repeated assessments become unnecessary, while maintaining the ability of insurers to provide medical reasons for any denials.

- No insurer should be able to spend more than a specified maximum on assessments in a non-catastrophic claim. Indeed, OTLA submits that there is no reason to spend more than 10 per cent of the available benefit amount (ie. $5,000) on assessments.

Income Replacement Benefits

The Supreme Court of Canada in *Smith v. Co-operators General Insurance Co.* made clear that the objective underlying the Statutory Accident Benefits Schedule is "consumer protection legislation". The erosion of available benefits under each successive SABS regime from 1996 to the present is completely at odds with the objective of protecting consumers.

In the case of income replacement benefits, it is difficult to understand how the interests of consumers have been protected. Despite almost two decades having passed, very little has changed in the availability of income replacement benefits for those whose injuries have prevented them from working.

The maximum available under the SABS for income replacement has remained static at $400 per week since 1996 – over 18 years ago.

Although the formula for quantifying the income replacement benefits changed from 80 per cent of net income to 70 per cent of gross income in 2010, the income replacement benefit for someone who is unable to work remains capped at $400 per week.

Although the basic income replacement benefit level of $400 per week can be "optioned-up" to $600, $800 or $1,000 per week, relatively few Ontarians have opted for this coverage, or even understand that it exists. Moreover, even if purchased, consumers are not guaranteed to receive those increased benefit amounts. Many consumers may incorrectly assume that if they

are injured, they will automatically receive the higher amount they believe they have purchased. Quantification of the benefit, however, is determined based on the actual income earned by the claimant prior to the motor vehicle collision regardless of the enhanced coverage purchased. Additionally, higher income earners in Ontario are not likely to purchase enhanced coverage for income replacement benefits if they have other benefits available to them through group or private long-term disability plans.

It is OTLA's position that the maximum weekly entitlement for income replacement benefits ought to be raised from $400 to $600.

From November 1996 to today, the consumer price index has increased by 37.8 per cent In other words; $400 in November 1996 would be equivalent to $563.45 in 2014, according to the Bank of Canada Inflation Calculator. Despite that economic reality, the weekly income replacement benefit level has remained unchanged at $400.

It defies logic that income replacement benefits have not been adjusted since 1996. Tax credits are inflation-adjusted annually. Similarly, Canada Pension Plan Disability benefits paid by the federal government and other social assistance benefits are indexed annually for inflation. The reason for this is simple – those benefits are used to purchase food, shelter, and other goods, the price of which also increases by inflation every year. Why then, have income replacement benefits not been accorded the same treatment?

In January of 2014, it was announced that Ontario is increasing minimum the wage to $11.00 per hour on June 1, 2014. As stated on the Government of Ontario website, “Ontario is acting on the recommendations put forward by the Minimum Wage Advisory Panel to ensure a fair, competitive, and predictable wage system for both workers and businesses in the province”. In addition, effective 2015, increases reflecting the Consumer Price Index will be announced annually each April and take effect the following October.

It is noteworthy that in 1996, when the maximum income replacement benefit was introduced at $400 per week, the minimum wage was just $6.85 per hour.

The stated importance to the government of a ``fair, competitive and predictable wage system” for Ontario workers, as reflected in the increase to the minimum wage, logically and reasonably ought to be extended to Ontario workers who are injured in motor vehicle accidents and unable to work. Why should Ontario workers not be afforded the same entitlement to fair, competitive and predictable benefits at their time of greatest need – the time of injury?

It should not be overlooked that the first no-fault scheme, Ontario Motorist Protection Plan, which was introduced almost 24 years ago, permitted insured persons to claim income replacement benefits, based on 80 per cent of gross income, to a maximum of $600 per week. Tort rights were also available at that time for economic loss.

The number of persons who would be impacted by the proposed increase in the maximum income benefit entitlement to $600 per week would be relatively modest, given the average income of Ontarians and those who have access to collateral source benefits such as private and group disability plans. Consequently, the proposed change would cost relatively little, but would go a long way toward helping injured persons and their families to subsist at a time of crisis.

Attendant Care Benefits

Since 1996, the nature and extent of attendant care needs of an injured person have been determined on the basis of the parameters set out in the Form 1 Assessment of Attendant Care Needs form, known colloquially as "Form 1". The Form 1 classifies an injured person's weekly attendant care needs at various levels of care and applies a statutory hourly rate to each level to calculate the total monthly attendant care benefit required by the injured person.

From 1996 to 2010, family members who provided attendant care to injured persons were compensated for the value of those services provided in accordance with the Form 1. However, in September 2010, the Ontario government amended the SABS to now require that family members prove that they have incurred an "economic loss" in providing that care. In 2013, the Ontario Court of Appeal in *Henry v. Gore Mutual Insurance Company* concluded that, once a family member proved that they had incurred an "economic loss," the amount of the attendant care benefit was to be calculated at the Form 1 rate, not limited to the quantum of the "economic loss" incurred by the caregiver.

Passage of Regulation Ontario Regulation 347/13

On February 1, 2014 Ontario Regulation 347/13 came into force, legislatively reversing *Henry v. Gore Mutual*, and limiting attendant care benefits for family members who provide attendant care services to the amount of the family member's actual economic loss in providing attendant care services. This regulation was enacted two days after the government announced an

increase in the minimum hourly wage to $11.00, and only three days after the regulation itself was publicly announced. There was no consultation with stakeholders in the legal community, including OTLA, regarding Regulation 347/13.

Fair Wages

This regulatory limit on attendant care benefits is in direct conflict with Ontario's minimum wage laws. Family members who take time away from their work to provide attendant care services, or who give up their jobs entirely for that purpose, will now potentially be required to do so at a rate substantially lower than the statutory minimum hourly wage of $11.00 per hour. Consider the example of a mother who was previously working 20 hours per week at $11.00 per hour, and who leaves her employment to provide 12 hours of daily care to her injured child. Under the new system, that mother will receive an attendant care benefit equal to only $2.61 per hour of attendant care service provided. This undermines the purpose of the recent change to the minimum wage law, which was to ensure that all Ontario workers are paid a fair wage.

Encouraging Family Care and Promoting Consumer Choice

The Ontario government has historically recognized the importance of family members being fairly compensated for providing needed attendant care services. Not surprisingly, injured people generally prefer to receive these intimate care services, often required to be provided at odd hours, from family members. In addition, the statutorily prescribed hourly rates in the Form 1 are substantially lower than actual market rates for attendant care services. The only way for an injured person to receive the necessary attendant care is to rely upon friends or family members. The current average market rate for attendant care services is $23.00 per hour, while the Form 1 maximum rates, according to the Superintendent's Guideline No. 03/10, are $13.19 per hour (for routine personal care), $10.25 per hour (for basic supervisory functions), and $19.35 per hour (for complex care and hygiene functions). The provision of attendant care services by family members is, therefore, something that ought to be encouraged. Regulation 347/13 ensures that victims will have to rely upon charity from friends and family, or go without this necessary care. This will have a negative impact on that victim's ability to recover from their injuries and return to work.

Excessive Transaction Costs

The new, two-step, valuation of attendant care benefits has also introduced an additional layer of complexity and transaction costs. This process now requires the completion of a Form 1 followed by the calculation of the family member's economic loss. In many cases, the calculation of the economic loss will require the review of income tax returns and payroll documentation, in addition to any other information supporting other economic losses, before the benefit level can be calculated. In the case of self-employed people, detailed reviews of revenue and expense records, financial statements and income tax returns may be required. In addition, this two-step valuation process gives rise to a new category of disputes about the nature and quantum of the economic loss. The introduction of this increased complexity and cost is inconsistent with the push to simplify and streamline the SABS. In many cases, the costs of obtaining the valuations of the economic loss, and the costs of litigating disputes about the true value of the economic loss, will outweigh the value of the actual attendant care benefit itself.

Finally, attendant care is a critical component in maximizing medical recovery and function of an injured person, but attendant care is available only to the 25 per cent of accident victims whose injuries fall outside the Minor Injury Guideline. For these accident victims, the attendant care benefit is time-limited to two years from the date of the accident if they have not suffered a catastrophic impairment. The provision of this needed care for even a brief period of time helps accident victims improve and return to work, while the flexibility that family-delivered care allows, helps to minimize unnecessary emotional and familial stress.

For all of these reasons, and to ensure consistency with Ontario's minimum wage laws, family members who provide attendant care services should be compensated according to the level of service they provide, and not on the basis of their provable economic loss which bears no direct relationship to the services provided the injured person. OTLA recommends the immediate repeal of the February 1, 2014 Attendant Care Benefits changes.

The Minor Injury Guideline (MIG)

Introduced in September 2010, the Minor Injury Guideline ("The MIG") reduced the maximum insurance coverage available for treatment and medical expenses to $3,500 for persons who sustain minor injuries in automobile accidents. Prior to September 2010, any person injured in an automobile accident had a limit of $100,000.00 available for needed treatment and medical care. The MIG has now been in place for over three years. Statistics from the Insurance Bureau of Canada and the Financial Services Commission of Ontario reveal that close to 80 per cent of all people injured in automobile accidents are being placed into the MIG by their automobile

insurance companies. OTLA is of the view that the Ontario government established the MIG, at the urging of the insurance industry, as a means of attempting to rein in treatment clinics that were perceived by the insurance industry to be over charging. OTLA submits that the government did not properly consider the treatment injured persons should be able to receive in order to best help them recover from their injuries.

OTLA is of the view that the government adopted the strategy that, if it slashed the treatment limit to $3,500, then the unethical treatment clinics that existed would no longer be able to continue their unethical practices. Unfortunately, the government has 'thrown the baby out with the bath water.' In its zeal to control treatment clinics, the government sacrificed the rehabilitation needs of many injured people.

In 1989, every automobile insurance policy in Ontario provided up to $25,000 in coverage for necessary treatment to those injured in automobile accidents. After adjusting for inflation, the current $3,500 MIG treatment maximum is less than 10% of the available maximum in 1989. Insurance company profits have grown dramatically since many previously available benefits were eliminated in September 2010, along with the introduction of the MIG. The benefits that were eliminated were in some cases extremely important to help injured people overcome the impact that their injuries were having on their lives.

The rationale for bringing in the MIG was disingenuous since it was directed at treatment clinics and not at the legitimate treatment needs of injured people. The definition of "minor injury" in the MIG is unduly broad and all-encompassing and, as statistics have shown, it is being applied by the insurance industry to almost 80 per cent of all persons injured in automobile accidents. The MIG was never intended to be so all encompassing. The MIG was established to cover the average treatment costs for a very simple, uncomplicated whiplash-type injury. As presently worded, insurers are applying the MIG to many injuries, such as tendon and ligament tears and joint dislocations and even head injuries, that should have never been included in the definition. Injuries such as shoulder dislocations, rotator-cuff tears, concussions, etc., are more serious and often require significant treatment and longer recovery times. These injuries should not be placed into the MIG and should not be classified as minor. The government needs to refine and narrow the scope of injuries that are covered by the MIG so as to better permit injured people to obtain proper treatment for their injuries.

Conclusion

OTLA appreciates the opportunity to provide meaningful input into the various issues discussed in this submission. OTLA is in the unique position of being able to speak on behalf of future accident victims - those who have not yet had the misfortune of being involved in an accident; a voice that would otherwise not be heard in this process. Unfortunately there is a recent and troubling trend for changes to be made to the auto insurance system in Ontario without any consultation whatsoever. It is not surprising that those changes related to the removal or substantial diminution of the rights of accident victims and the benefits to which they are entitled.

One can only speculate as to why the government chose to make these unilateral and arguably misguided policy decisions. However, it is certain that in making these decisions without all the available information or facts, the government has created a new problem that will need to be addressed at a future date. Certainly, when governments quietly release policy decisions at the end of a legislative session just before a major holiday, it suggests that they recognized that their policies were at best controversial and they anticipated that they would not be well received by many stakeholders.

Apart from the lack of consultation with stakeholders, certain reductions in benefits also appear to have been conceived in a vacuum, without due regard to the reality that limiting or eliminating essential benefits on the first-party side will only force claimants to shift their pursuit of the benefit to the third-party side, assuming a viable tort claim exists. For example, the cuts that were made to the attendant care provisions, and in particular limiting the benefit to the quantum of the "economic loss" sustained by the care provider, will increase those costs being claimed in the related tort action. When those costs rise, the industry will of course point the finger at innocent accident victims and their lawyers. Most people simply will not get the care that they require as they cannot afford to pay for it. When they do not get better, when chronic pain and emotional issues become entrenched, the industry will of course point the finger at innocent accident victims and their lawyers. OTLA could have helped to provide input into solutions that would have met the interests of all parties (for example, providing reasonable payment to family members, but for a limited time period to provide acute, not chronic, care), but OTLA was not consulted. Currently, Bill 171 has proposed reducing the prejudgment interest rate for pain and suffering damages, again without consulting any legal organizations. The extra delay that will arise, and the resulting backlog within, and cost to, our Court system, might have been avoided had consultation occurred.

OTLA understands that changes need to be made to the auto insurance system from time to time. In recent years, the majority of those "changes" have been in the form of cuts to benefits

and restrictions of tort rights. But consultation with knowledgeable stakeholders, such as OTLA, must be a precondition before any changes of substance ought to be made to the auto insurance system. Whether OTLA agrees or not with proposed changes, and whether decision makers agree with the input provided by OTLA, there is never any justification to purposefully avoid consulting with OTLA, and at least considering the input that we can provide from our unique perspective. All Ontarians are worse off when decision makers lose the benefit of useful information because those decisions are made behind closed doors, at the insistence of a special interest group like the Insurance Bureau of Canada.

The changes proposed by OTLA in this paper will improve the product, promote stability, augment access to justice, and meet with the approval of the public. OTLA values its role as a significant stakeholder in this process and welcomes the opportunity for further discussion and consultation as the necessary changes are considered and implemented.